REPORT OF RABIES POST-EXPOSURE TREATMENT - Page 1 of 2

Indiana State Department of Health State Form 51726 (10-04).

To be completed by the treating physician or hospital representative at the completion of treatment; forward to the local health officer where the patient resides.

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:		
1 Print firmly and neatly. 3 Fill in circles like this: • 4 Pr	int capital letters only d numbers completely The property of the property o	
	a numbers completely	
black ink. Mark mistakes like this: installed in the state of the stat	side boxes.	
Section 1. Demographic Information		
Last Name		
First Name	MI Phone Number	
Number & Street Address		
City	State ZIP Code	
County	Date of Birth Age	
Race: O Asian O Black or African American O American Indian or Alaska Native O Native Hawaiian or Other Pacific Islander Ethnic O Hisp Sex: O Male	panic or Latino O Not Hispanic or Latino O Unknown day/mo/yr? O Days O Months	
Section 2. Clinical Information		
L		
Physician/Hospital Where Treatment Initiated Physician/Hospital Address		
	State ZIP Code	
Physician/Hospital Address	State ZIP Code	
Physician/Hospital Address City	State ZIP Code Part of Body Exposed (check all that apply): ○ Face/Neck/Head	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply):	Part of Body Exposed (check all that apply): O Face/Neck/Head	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply): O Multiple Bite	Part of Body Exposed (check all that apply):	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply): Multiple Bite Single Bite Contamination of an abrasion, cut, open wound, or	Part of Body Exposed (check all that apply): O Face/Neck/Head O Finger	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply): Multiple Bite Single Bite Scratch	Part of Body Exposed (check all that apply): O Face/Neck/Head O Finger O Hand/Foot O Leg/Arm	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply): Multiple Bite Single Bite Contamination of an abrasion, cut, open wound, or mucous membrane with SALIVA or CNS fluid	Part of Body Exposed (check all that apply): O Face/Neck/Head O Finger O Hand/Foot	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply): Multiple Bite Single Bite Scratch Contamination of an abrasion, cut, open wound, or mucous membrane with SALIVA or CNS fluid Unknown	Part of Body Exposed (check all that apply): O Face/Neck/Head O Finger O Hand/Foot O Leg/Arm O Trunk	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply): Multiple Bite Single Bite Scratch Contamination of an abrasion, cut, open wound, or mucous membrane with SALIVA or CNS fluid Unknown Other, specify: Type of Rabid/Suspect Rabid Animal Involved in Exposure: Bat Dog Skunk Ferret	Part of Body Exposed (check all that apply): O Face/Neck/Head O Finger O Hand/Foot O Leg/Arm O Trunk	
Physician/Hospital Address City Physician/Hospital Phone Type of Human Exposure (check all that apply): Multiple Bite Single Bite Scratch Contamination of an abrasion, cut, open wound, or mucous membrane with SALIVA or CNS fluid Unknown Other, specify: Type of Rabid/Suspect Rabid Animal Involved in Exposure:	Part of Body Exposed (check all that apply): O Face/Neck/Head O Finger O Hand/Foot O Leg/Arm O Trunk	

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Section 2. Clinical Information (Continued)

Circumstances of Exposure (check all that apply): O Completely unprovoked attack by rabid/suspect rabid animal O Attacked while entering area guarded by rabid/suspect rabid animal O Provoked attack (feeding/petting/touching/playing/picking up/treating/nursing/examining/consoling rabid or suspect rabid animal) O Treating/nursing/examining/consoling pet/animal which had conflict with suspect rabid animal O Skinning/dressing rabid/suspect animal carcass O Unknown O Other, specify:		
Date of Exposure Date Treatment Began		
Rabies Status of Exposing Animal: O Tested positive	Type of Treatment: O HRIG plus 5 doses of vaccine	
O Tested negative	O 2 doses of vaccine (for pre-vaccinated individuals)	
O Under confinement	O Incomplete course (treatment stopped after animal determined to be negative for rabies)	
O Not available	O Incomplete course (treatment stopped by patient)	
O Testing requested but owner did not permit	O Treatment course initiated by patient lost to follow up	
O Other, specify:	O Unknown	
	O Other, specify:	
Comments:		
Name of Person Submitting Report	Title	
Clamatura	Phane Number	
Signature	Phone Number	
Name of Health Department		